REVIEW OF MEDICARE REQUESTS FOR EXPEDITED SERVICE ORGANIZATION DETERMINATIONS WS-AP4

ID/Member Name/Type	Date Expedited Service Request Received	~~Favorable:~~ Oral notice in 72 hrs?* F/U in writing ~~2~~ ~~working~~ within 3 calendar days? ~~Date service effectuated?~~	Unfav. Notice to Enrollee Date	Denial Proper?	Correct Appeal Language Provided?	POS?	Comments

Standard: 95 percent correct.

Determination: Transfer results of this sample to the appropriate requirements the Appeals Section of the *Review Guide*. See Column Explanations for coded requirements related to specific columns. *See next page.

Requirement:

*ALL EXPEDITED SERVICE RELATED DECISIONS MUST BE MADE AS EXPEDITIOUSLY AS THE ENROLLEE S HEALTH CONDITION REQUIRES BUT NO LATER THAN 72 HOURS AFTER RECEIVING THE REQUEST. THE M+CO MAY EXTEND THE 72-HOUR DEADLINE BY UP TO 14 CALENDAR DAYS IF THE ENROLLEE REQUESTS THE EXTENSION OR IF THE ORGANIZATION JUSTIFIES A NEED FOR ADDITIONAL INFORMATION AND HOW THE DELAY IS IN THE INTEREST OF THE ENROLLEE.

The M+CO must make an organization determination (the M+CO's decision to provide, to authorize or to deny a service) within: 1) 72 hours of the enrollee's request for the service, 2) or expiration of the extension ~~(which may be up to 14 days, if the enrollee requests it or if an extension is in the interest of the beneficiary).~~. Failure to provide a notice constitutes an adverse organization determination, which the member may appeal. The M+CO must notify the member if it has failed to make a timely decision. Failure to make a timely decision constitutes an adverse determination, and the M+CO must include Appeal Rights.

(1.) The M+CO must expedite: ~~1~~a) physician requests for expedited determination ~~(when the physician is an authorized rep.)~~, ~~2~~b) enrollee requests with oral or written physician support statements, if the physician indicates that applying the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function; and ~~3~~c) an enrollee request when applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or enrollee's ability to gain maximum function.

(2.) If an M+CO denies the request for an expedited determination, the M+CO must: ~~1~~a) ~~it must process the request and make a determination under the standard time frame,~~ give the enrollee prompt oral notice of the denial and subsequently deliver, within 3 calendar days, a written letter; (b) explain the M+CO will process the request using the 14-day timeframe for standard determinations; ~~2~~) ~~notify the enrollee promptly (orally) with a written follow-up within 2 working~~ days (c) provide instructions about the grievance process and its timeframes ; and (d) inform the enrollee of the right to resubmit a request for an expedited determination with any physician's support.

Purpose: To determine whether the M+CO complies with regulatory requirements of identifying expedited organization determinations involving a request for a service, in a timely manner. To determine whether the M+CO inappropriately denied services; e.g., Medicare-covered services, emergency, urgently needed, and post stabilization care, as well as temporarily out of area renal dialysis services, services rendered pursuant to a POS benefit, and supplemental (mandatory and optional) benefits covered in the M+CO s subscriber agreement.

Sample: In the notification of a site visit letter, a reviewer will request the M+CO to provide a list of all approved and denied expedited preauthorization/authorization cases (Note: If the M+CO delegates this function to medical groups or IPAs, ask for lists from the groups) in the 6-month period ending with the month prior to the scheduled visit (the specific months should be specified in the letter). If the M+CO offers a POS benefit, be sure to include any POS cases that require preauthorization/authorization from the M+CO (or delegated entities). Depending upon the number of enrollees in the POS product, the reviewer may, at his or her discretion, request a separate universe of POS-only expedited preauthorizations/authorizations for review.

Upon receipt of the list, approximately two weeks prior to the site visit, the reviewer will select 30 cases of plan expedited preauthorizations/authorizations (if the plan contracts with multiple groups, select a sample that includes authorizations from at least three groups) in accordance with the random selection methods discussed in the *Review Guide*, Instructions under Sampling Methodology. ***(Note: During focused reviews, HCFA staff may elect to increase sample sizes to 100 cases or more, as deemed appropriate by the Agency.)*** Five (5) to seven (7) days before the site visit, the reviewer will notify the M+CO of the specific units of analysis. The M+CO will have all necessary documentation for the units of analysis available upon the reviewer's arrival onsite.

Column Explanations:

ID/Member Name/Type: Self-explanatory. Number optional.

Date Expedited Service Request Received: Self-explanatory.

~~Processed~~ Oral notice within 72 Hours*: Did the M+CO render a decision and notify the enrollee within 72 hours* of the request? If an extension was granted, did the M+CO notify the enrollee in writing? (Transfer results to AP03A.) If the M+CO notified the enrollee of its expedited determination orally, did the M+CO mail written confirmation to the enrollee within 3 calendar days of the oral notification? Transfer results to AP01, AP03.

Unfavorable Notice to the Enrollee Date, Use this column to show what date the unfavorable notice was sent. AP04

Denial Proper: Was a written denial notice issued and does the notice clearly explain the reason for the denial in language that the enrollee can understand? Not a covered benefit or Medical Necessity not Met does not give sufficient information to explain the denial. Transfer results to ~~AP03, AP03A~~, AP04, AP05.

Correct Appeal Language Provided: Were full written appeal rights given? Does the notice include the correct address for filing the appeal? Transfer results to AP01~~, AP03A, AP04~~, AP05.

Comments: Self-explanatory. You may want to include comments here (e.g., reason for denial) that would help you focus on trends.

NOTE TO REVIEWER: If the M+CO is unable to provide a universe (or if a delegated entity cannot provide a universe), have the M+CO (or delegated entity) provide a list of members who have recently changed PCPs. Have the M+CO (delegated entity) provide the reason codes for the PCP changes. Review the list. If the M+CO (delegated entity) does not capture the reason for PCP change, call ten (or more) members from the list at random. If it appears that members have changed PCPs because they were not receiving referrals or services they felt they needed, but they were not receiving appeal rights when referrals/services were denied, consider requiring the M+CO (delegated entity) to post signs in offices where health care is delivered related to the Medicare appeal process, including an M+CO telephone number to call for questions.